MEDI-CAL UPDATE Part 2
Billing and Policy
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Outpatient Services • Rehabilitation Clinics

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Contents

CMC Claim Submission for Medicare/Medi-Cal Crossover Billers

Medi-Cal can now receive electronic crossover claims directly from approved submitters via the ASC X12N 837 v.4010A1 transaction. Submitters using the 837 format must include Medicare payment information at the detail/claim line level. Additionally, Medi-Cal can receive electronic crossover claims automatically from Mutual of Omaha and United Government Services Medicare intermediaries for most Part B services billed to Part A intermediaries. This new provision primarily affects outpatient and dialysis providers who were previously required to bill these claims on paper. Providers of Part B services billed to Part A intermediaries other than Mutual of Omaha and United Government Services must continue to bill their claims directly to Medi-Cal either on paper or in the new HIPAA standard 837 electronic transaction until a new automatic crossover process is established with the Medicare Consolidated Coordination of Benefits Contractor sometime in 2006.

In order to comply with HIPAA electronic standards, providers billing crossover claims on paper for Part B services billed to Part A intermediaries will be required to attach the detail/claim line level *National Standard Intermediary Remittance Advice* (Medicare RA) to a *UB-92 Claim Form* and comply with revised billing instructions. Any claims received after October 24, 2005 that do not comply with the new billing and attachment requirements will be returned to providers for correction before processing.

Providers may obtain detailed Medicare RAs by printing the "Single Claim" report, which can be accessed through the latest version of PC Print software, available free of charge. PC Print software and instructions are available on the United Government Services Web site (**www.ugsmedicare.com**) by clicking "Providers," then "EDI" and then the "PC Print Software" link. Providers should obtain the PC Print software from Medicare as soon as possible to ensure they can print the appropriate Medicare RAs.

FluMist is New VFC Benefit

Effective for dates of service on or after November 1, 2005, FluMist (influenza virus vaccine, live, for intranasal use) is a new Vaccines For Children (VFC) benefit. Medi-Cal reimburses VFC providers an administration fee for providing the FluMist injection. Until further notice, FluMist will be billed to Medi-Cal with CPT-4 code 90749 (unlisted vaccine/toxoid) with modifiers -SK and -SL.

FluMist is reimbursable only for healthy individuals 5 through 18 years of age who are close contacts of people with chronic health conditions. Providers must document in the *Remarks* area, or on an attachment to the claim, that code 90749 was used to bill the VFC administrative fee for FluMist.

Please see **FluMist**, *page 2*

FluMist *(continued)*

Note: Retain this Article
Because code 90749 is being used to bill FluMist for a short time only, billing instructions are not being added to the provider manual. This article constitutes the official billing instructions for using code 90749 when billing FluMist and should, therefore, be retained by providers.

Looking Ahead
Early in 2006 unlisted code 90749 will be discontinued for billing the FluMist administration fee and this service will then be billed with CPT-4 code 90660 (influenza virus vaccine, live, for intranasal use). Modifiers -SK and -SL must still be used. Additional information and manual pages concerning the billing of FluMist will be released in a future *Medi-Cal Update*.

Menactra is New VFC and Medi-Cal Benefit

Effective retroactively to dates of service on or after May 27, 2005, Menactra (meningococcal vaccine) is a new Vaccines For Children (VFC) benefit. Medi-Cal reimburses VFC providers an administration fee for providing the Menactra injection. Until a dedicated CPT-4 code is announced, Menactra will be billed with CPT-4 code 90749 (unlisted vaccine/toxoid).

Menactra is a VFC benefit for recipients ages 11 through 18 years of age considered at high-risk for exposure to meningitis, such as those who are complement deficient, asplenic or living in close quarters such as college students in a dormitory. The Menactra administration fee is reimbursable when billed with modifiers -SL (VFC supplied vaccine) and -SK (members of high-risk populations).

Menactra also is a benefit of the Medi-Cal program. Under the Medi-Cal program Menactra is designated for use in recipients at high-risk who are between 19 and 55 years of age. Claims in this category are billed with modifier -SK.

For both children and adult recipients, providers must document in the *Remarks* area, or on an attachment to the claim, that code 90749 was used to bill the VFC administrative fee for Menactra. In addition, providers must document in the patient's office record the reason that the recipient is considered high-risk.

Note: Retain this Article
Because code 90749 is being used to bill Menactra for a short time only, billing instructions are not being added to the provider manual. This article constitutes the official billing instructions for using code 90749 when billing Menactra and should, therefore, be retained by providers.

Looking Ahead
Early in 2006 unlisted code 90749 will be discontinued for billing the Menactra administration fee and this service will then be billed with CPT-4 code 90734 (meningococcal conjugate vaccine, serogroups A, C, Y and W-135 [tetravalent], for intramuscular use). Modifiers -SK and -SL will still be used as outlined above. Additional information and manual pages concerning the billing of Menactra will be released in a future *Medi-Cal Update*.

DECAVAC is New VFC Benefit

DECAVAC is a new benefit for the Vaccines For Children (VFC) program. Medi-Cal reimburses VFC providers an administrative fee for providing the DECAVAC injection. DECAVAC is a diphtheria and tetanus toxoid [Td] adsorbed that is preservative free for use in individuals 7 years of age or older. For an interim period, this drug will be billed with CPT-4 code 90749 (unlisted vaccine/toxoid) and modifier -SL (VFC-supplied vaccine) retroactive to dates of service on or after January 1, 2005.

When billing code 90749, providers must document in the *Remarks* area, or on an attachment to the claim, that code 90749 was used to bill the VFC administrative fee for DECAVAC. At this time DECAVAC is not a benefit for Medi-Cal recipients ages 19 or older.

A special timeliness override has been developed in the claims processing system for DECAVAC claims submitted with code 90749.

Please see **DECAVAC**, *page 3*

DECAVAC *(continued)*

Note: Retain this Article
Because code 90749 is being used to bill DECAVAC for a short time only, billing instructions are not being added to the provider manual. This article constitutes the official billing instructions for using code 90749 when billing DECAVAC and should be retained by providers.

Looking Ahead
Early in 2006 unlisted code 90749 will be discontinued for billing the DECAVAC administration fee and this service will then be billed with CPT-4 code 90714 (diphtheria and tetanus toxoids [Td] adsorbed, preservative free, for use in individuals seven years of age or older, for intramuscular use). Modifier -SL must still be used. Additional information and manual pages concerning code 90714 will be released in a future *Medi-Cal Update*.

2006 ICD-9-CM Diagnosis Code Updates

The following diagnosis code additions, inactivations and revisions are effective for claims with dates of service on or after January 1, 2006. Providers may refer to the *2006 International Classification of Diseases, 9th Revision, Clinical Modifications, 6th Edition* for ICD-9 code descriptions.

Additions

259.50	276.50	276.51	276.52	278.02	287.30	287.31
287.32	287.33	287.39	291.82	292.85	327.00	327.01
327.02	327.09	327.10	327.11	327.12	327.13	327.14
327.15	327.19	327.20	327.21	327.22	327.23	327.24
327.25	327.26	327.27	327.29	327.30	327.31	327.32
327.33	327.34	327.35	327.36	327.37	327.39	327.40
327.41	327.42	327.43	327.44	327.49	327.51	327.52
327.53	327.59	327.8	362.03	362.04	362.05	362.06
362.07	426.82	443.82	525.40	525.41	525.42	525.43
525.44	525.50	525.51	525.52	525.53	525.54	567.21
567.22	567.23	567.29	567.31	567.38	567.39	567.81
567.82	567.89	585.1	585.2	585.3	585.4	585.5
585.6	585.9	599.60	599.69	651.70	651.71	651.73
760.77	760.78	763.84*****	770.10*****	770.11*****	770.12*****	770.13*****
770.14*****	770.15*****	770.16*****	770.17*****	770.18*****	770.85*****	770.86*****
779.84*****	780.95	799.01	799.02	996.40	996.41	996.42
996.43	996.44	996.45	996.46	996.47	996.49	V12.42
V12.60	V12.61	V12.69	V13.02	V13.03	V15.88	V17.81
V17.89	V18.9	V26.31	V26.32	V26.33	V46.13	V46.14
V49.84	V58.11	V58.12	V59.70**§**	V59.71****§**	V59.72****§**	V59.73†**§**
V59.74†**§**	V62.84	V64.00	V64.01	V64.02	V64.03	V64.04
V64.05	V64.06	V64.07	V64.08	V64.09	V69.5	V72.42**§**
V72.86	V85.0††	V85.1††	V85.21††	V85.22††	V85.23††	V85.24††
V85.25††	V85.30††	V85.31††	V85.32††	V85.33††	V85.34††	V85.35††
V85.36††	V85.37††	V85.38††	V85.39††	V85.4††		

Restrictions
***** Restricted to ages 0 thru 1 year
****** Restricted to ages 10 thru 35 years
† Restricted to ages 35 thru 55 years
†† Restricted to ages 18 thru 99 years
§ Restricted to females only

Please see **ICD-9 Updates**, *page 4*

ICD-9 Updates *(continued)*

Inactive Codes
Effective for dates of service on or after January 1, 2006, the following ICD-9 diagnosis codes are no longer reimbursable:

276.5, 287.3, 567.2, 567.8, 585, 599.6, 770.1, 799.0, 996.4, V12.6, V17.8, V26.3, V58.1, V64.0

Code Description Revisions
The descriptions of the following ICD-9 diagnosis codes are revised:

285.21, 307.45, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93, 728.87, 780.51, 780.52, 780.53, 780.54, 780.55, 780.57, 780.58

All manual replacement pages reflecting these ICD-9 code updates will be included in future *Medi-Cal Updates*.

Additional Reimbursement Criteria for Hepatitis A and B Combo

Effective for dates of service on or after December 1, 2005, CPT-4 code 90636 (hepatitis A and hepatitis B combination vaccine) is reimbursable for any recipient 19 years of age or older who is at risk of developing hepatitis A and/or hepatitis B due to the following:

- Receives blood factor products, either for the treatment of a medical disorder or as an occupational exposure
- Has chronic liver disease
- Had a liver transplant
- Uses illicit injectable or non-injectable "street" drugs
- Is a male having sex with other males
- Individuals in high risk situations, such as day-care centers, hemodialysis units, drug and alcohol treatment centers, correctional facilities and places where emergency medical assistance is rendered
- Has come in contact with blood, body fluids, feces or sewage
- Has come in contact with live hepatitis A and/or B virus

The updated information is reflected on manual replacement page inject 48 (Part 2).

Modifier Sections Updated in Provider Manual

Due to a consolidation of information regarding modifier policy, the Department of Health Services is removing the section *Modifiers for Outpatient Services* ("modif op") and adding the section *Modifiers* ("modif"). All Medi-Cal policy remains the same. All policy found in *Modifiers for Outpatient Services* is now in *Modifiers*.

Inpatient Provider Cutoff Date for Proprietary and Non-HIPAA Standard Electronic Claim Formats: December 1, 2005

In accordance with efforts to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPAA), Medi-Cal is planning to discontinue acceptance of proprietary and non-HIPAA standard electronic formats for electronic claim transactions. The first provider community to be affected is the Inpatient provider community.

Beginning **December 1, 2005,** proprietary and non-HIPAA standard electronic claim formats submitted by Inpatient providers will no longer be accepted.

Self-Service HIPAA Transaction Utility Tool
A self-service environment, HIPAA Transaction Utility Tool, will soon be available for submitters. Initially, the utility tool will be available only for inpatient submitters to validate ASC X12N 837 v.4010A1 transactions in preparation for proprietary format discontinuance. However, the utility tool will become available to other submitter communities as their timeline for proprietary format discontinuance is determined.

The utility tool will offer transaction validation (inclusive of Companion Guide-level editing), troubleshooting and reporting features that enhance, but do not replace, Medi-Cal's current testing and media activation requirements. Inpatient submitters have been notified of the utility tool's availability via e-mail or letter depending on information availability.

Providers may call the Telephone Service Center (TSC) at 1-800-541-5555 for more information.

Cutoff dates for non-HIPAA standard claim formats for all other provider communities will be announced in upcoming *Medi-Cal Updates*.

Instructions for Manual Replacement Pages — Part 2

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Remove and replace:	*Contents for Rehabilitation Clinics Billing and Policy iii/iv* ***** inject 47/48
Remove:	inject 53
Insert:	inject 53/54 *(new)* *
Insert new section after *Medicare Non-Covered Services: HCPCS Codes* section:	modif 1 thru 3 *(new)*
Remove:	modif op 1/2
Remove and replace:	speech cd 1/2 *

* Pages updated due to ongoing provider manual revisions.